LOUISIANA STANDARDIZED CREDENTIALING APPLICATION

DIRECTIONS

Please type or print in black ink when completing this form. If you need more space, attach additional sheets and reference the question being answered. Please see page 9 for a list of required documents.

**** All sections must be completed in their entirety. "See C.V.", not acceptable****

GENERAL INFORMATION

LAST NAME	FIRST	MIDDLE	GENDER
			⊙ MALE ○ FEMALE

DEGREE: ☐ MD ☐ DO ☐ DPM ☐ DC ☐ DDS ☐ DMD ☐ OTHER_____

Any other name under which you have been known? (AKA) LIST	ECFMG NUMBER	UPIN NUMBER	
HOME STREET ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE NUMBER	PAGER NUMBER/ANSWERING SERVICE	E-MAIL ADDRESS

SOCIAL SECURITY NUMBER	DATE OF BIRTH	BIRTH PLACE (CITY, STATE)	BIRTH COUNTRY
ALIEN REGISTRATION NUMBER	CITIZENSHIP	MEDICARE PROVIDER NUMBER	MEDICAID PROVIDER NUMBER

PRIMARY PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)

STREET ADDRESS	CITY	STATE	ZIP CODE

PHONE NUMBER	FAX NUMBER	OFFICE MANAGER

TYPE OF PRACTICE: ☐ SOLO ☐ MULTISPECIALTY ☐ GROUP ☐ SINGLE SPECIALTY GROUP ☐ HOSPITAL-BASED

TAX IDENTIFICATION NUMBER	DATE TAX ID # EFFECTIVE

Name to which tax ID number is registered with the IRS (Important: Must match the name given on the enclosed W-9 form)

BILLING ADDRESS (Address to which you want payments sent)	CONTACT PERSON	TELEPHONE NUMBER
CITY STATE ZIP CODE	BILLING E-MAIL	FAX NUMBER

OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
	____-____	____-____	____-____	____-____	____-____	____-____	____-____

Do you practice at this location: ☐ Full-time ☐ Part-time ☐ Other (Specify) _____

Languages spoken at this location: (other than English)

Accepting Patients? ☐ New ☐ Existing Only ☐ Only family members of existing patients ☐ Other (Specify)

Age group(s) treated: ☐ 0-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other (Specify) _____

Are PA's and/or nurse/paraprofessional practitioners used? ○ Yes ○ No

Is this facility handicapped accessible? ○ Yes ○ No

Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)

Group or Covering Physicians:

SECOND PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)

STREET ADDRESS	CITY	STATE	ZIP CODE

PHONE NUMBER	FAX NUMBER	OFFICE MANAGER

TYPE OF PRACTICE: ☐ SOLO ☐ MULTISPECIALTY ☐ GROUP ☐ SINGLE SPECIALTY GROUP ☐ HOSPITAL-BASED

TAX IDENTIFICATION NUMBER	DATE TAX ID # EFFECTIVE

Name to which tax ID number is registered with the IRS (Important: Must match the name given on the enclosed W-9 form)

BILLING ADDRESS (Address to which you want payments sent)	CONTACT PERSON	TELEPHONE NUMBER

CITY STATE ZIP CODE	BILLING E-MAIL	FAX NUMBER

OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____

Do you practice at this location: ☐ Full-time ☐ Part-time ☐ Other (Specify): _____

Languages spoken at this location: (other than English) _____ _____

Accepting Patients? ☐ New ☐ Existing Only ☐ Only family members of existing patients ☐ Other (Specify): _____

Age group(s) treated: ☐ 0-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other (Specify): _____

Are PA's and/or nurse/paraprofessional practitioners used? ○ Yes ○ No | Is this facility handicapped Accessible? ◉ Yes ○ No

Emergency After Hours Number	Arrangements for 24 hour / 7 day a week coverage (Specify)

Group or Covering Physicians:

THIRD PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)

STREET ADDRESS	CITY	STATE	ZIP CODE

PHONE NUMBER	FAX NUMBER	OFFICE MANAGER

TYPE OF PRACTICE: ☐ SOLO ☐ MULTISPECIALTY ☐ GROUP ☐ SINGLE SPECIALTY GROUP ☐ HOSPITAL-BASED

TAX IDENTIFICATION NUMBER	DATE TAX ID # EFFECTIVE

Name to which tax ID number is registered with the IRS (Important: Must match the name given on the enclosed W-9 form)

BILLING ADDRESS (Address to which you want payments sent)	CONTACT PERSON	TELEPHONE NUMBER

CITY STATE ZIP CODE	BILLING E-MAIL	FAX NUMBER

OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____	_____-_____

Do you practice at this location: ☐ Full-time ☐ Part-time ☐ Other (Specify): _____

Languages spoken at this location: (other than English) _____ _____

THIRD PRACTICE LOCATION CONTINUED

Accepting Patients? ☐ New ☐ Existing Only ☐ Only family members of existing patients ☐ Other (Specify): _____

Age group(s) treated: ☐ 0-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other (Specify): _____

Are PA's and/or nurse/paraprofessional practitioners used? ◯ Yes ◯ No | Is this facility handicapped Accessible? ☐ Yes ☐ No

Emergency After Hours Number | Arrangements for 24 hour / 7 day a week coverage (Specify)

Group or Covering Physicians:

FOURTH PRACTICE LOCATION

INSTITUTION/GROUP/CLINIC NAME (If applicable)

STREET ADDRESS | CITY | STATE | ZIP CODE

PHONE NUMBER | FAX NUMBER | OFFICE MANAGER

TYPE OF PRACTICE: ☐ SOLO ☐ MULTISPECIALTY ☐ GROUP ☐ SINGLE SPECIALTY GROUP ☐ HOSPITAL-BASED

TAX IDENTIFICATION NUMBER | DATE TAX ID # EFFECTIVE

Name to which tax ID number is registered with the IRS (Important: Must match the name given on the enclosed W-9 form)

BILLING ADDRESS (Address to which you want payments sent) | CONTACT PERSON | TELEPHONE NUMBER

CITY STATE ZIP CODE | BILLING E-MAIL | FAX NUMBER

OFFICE HOURS	MON	TUES	WED	THUR	FRI	SAT	SUN
	____-____	____-____	____-____	____-____	____-____	____-____	____-____

Do you practice at this location: ☐ Full-time ☐ Part-time ☐ Other (Specify): _____

Languages spoken at this location: (other than English) _____ _____

Accepting Patients? ☐ New ☐ Existing Only ☐ Only family members of existing patients ☐ Other (Specify): _____

Age group(s) treated: ☐ 0-11 years ☐ 12-18 years ☐ 19-65 years ☐ Over 65 ☐ All Ages ☐ Other (Specify): _____

Are PA's and/or nurse/paraprofessional practitioners used? ◯ Yes ◯ No | Is this facility handicapped Accessible? ◯ Yes ◯ No

Emergency After Hours Number | Arrangements for 24 hour / 7 day a week coverage (Specify)

Group or Covering Physicians:

CORRESPONDENCE

Please check location where you would like correspondence sent.

☐ Primary ☐ Second ☐ Third ☐ Fourth ☐ All

☐ Other Address_____ ____

_____ ____

SPECIALTY

TYPE OF PROVIDER: ☐ PRIMARY CARE PHYSICIAN ☐ PHYSICIAN SPECIALIST ☐ BOTH ☐ OTHER SPECIALTY: _____

PLEASE LIST PRIMARY AND SUB-SPECIALTIES (as applicable)	BOARD CERTIFIED (ABMS)	OTHER
Specialty:	○ Yes ○ No	☐
Sub-Specialty:	○ Yes ○ No	☐
Sub-Specialty:	○ Yes ○ No	☐

BOARD CERTIFICATION

(as recognized by American Board of Medical Specialties)
(Please attach a copy of current certification(s).)

PRIMARY SPECIALTY BOARD (ABMS)	DATE CERTIFIED	DATE RECERTIFIED	STATUS/EXP. DATE
SECONDARY SPECIALTY BOARD (ABMS)	**DATE CERTIFIED**	**DATE RECERTIFIED**	**STATUS/EXP. DATE**

Complete Questions 1-5 below if you are currently pursuing any board certification.

1. If you have applied to a specialty board for examination, give the name of the board and date of application:

BOARD NAME _____ APPLICATION DATE _____

2. List any board certification results pending (include certifying board and exam date taken):

CERTIFYING BOARD _____ DATE TAKEN _____

3. If you are eligible to sit for an exam, give the year eligibility will terminate under rules of the specific board:

BOARD NAME _____ TERMINATION DATE _____

4. If not board certified, do you intend to apply? (If YES, give board name and date) ○ Yes ○ No

BOARD NAME _____ ANTICIPATED APPLICATION DATE _____

5. Have you ever taken the examination for a specialty board and not been granted certification? ○ Yes ○ No

CERTIFYING BOARD _____ DATE TAKEN _____

DIRECTORY INFORMATION

Check whether the specialty and/or subspecialty(ies) listed above are practiced at each location. Indicate if each specialty is to be noted in the directory. **DISCLAIMER: Use of information may vary by health care organization**

Primary Location	Second Location	Third Location	Fourth Location
☐ Specialty ☐ Directory	☐ Specialty ☐ Directory	☐ Specialty ☐ Directory	☐ Specialty ☐ Directory
☐ Sub-specialty ☐ Directory	☐ Sub-specialty ☐ Directory	☐ Sub-specialty ☐ Directory	☐ Sub-specialty ☐ Directory
☐ Sub-specialty ☐ Directory	☐ Sub-specialty ☐ Directory	☐ Sub-specialty ☐ Directory	☐ Sub-specialty ☐ Directory

PHO / IPA AFFILIATIONS*

List any other PHO's, IPA's, which you participate in and dates of participation:

** The intent of this section is to identify any contractual arrangements the physicians have that are in direct conflict with the Plan.*

CURRENT HOSPITAL AFFILIATION

List the hospital to which you primarily admit your patients: _____

List in chronological order all hospitals at which you currently have privileges:

HOSPITAL	LOCATION/ADDRESS	TYPE OF PRIVILEGES	EFFECTIVE DATE MO/YR

EDUCATION

IF ADDITIONAL TRAINING HAS BEEN COMPLETED, PLEASE ATTACH ON A SEPARATE FORM.

MEDICAL/PROFESSIONAL SCHOOL:		
CITY	STATE	ZIP
DEGREE	YEAR OF GRADUATION	DATES ATTENDED (MO/YR) From To
INTERNSHIP: INSTITUTION NAME	TYPE OF TRAINING	
CITY	STATE	
UNIVERSITY AFFILIATION	COMPLETED ○ YES ○ NO	DATES ATTENDED (MO/YR) From To
RESIDENCY: INSTITUTION NAME	TYPE OF RESIDENCY	☐ Clinical ☐ Research
CITY	STATE	DATES ATTENDED (MO/YR) From To
UNIVERSITY AFFILIATION	COMPLETED ○ YES ○ NO	
RESIDENCY: INSTITUTION NAME	TYPE OF RESIDENCY	☐ Clinical ☐ Research
CITY	STATE	DATES ATTENDED (MO/YR) From To
UNIVERSITY AFFILIATION	COMPLETED ○ YES ○ NO	
FELLOWSHIP: INSTITUTION NAME	SPECIALTY FIELD	DATES ATTENDED (MO/YR) From To
CITY	STATE	COMPLETED ○ YES ◉ NO
	TYPE OF FELLOWSHIP	☐ Clinical ☐ Research
FELLOWSHIP: INSTITUTION NAME	SUBSPECIALTY FIELDS	DATES ATTENDED (MO/YR) From To
CITY	STATE	COMPLETED ○ YES ○ NO
	TYPE OF FELLOWSHIP	☐ Clinical ☐ Research

WORK HISTORY

Using the following codes, please list in chronological order your work history from the time you completed your medical training to the present. It is very important that you use the month and year for each entity listed.

CODE:

C = Clinic/Group **S** = Solo Practice **A** = Academic (Paid Teaching Appointments) **H** = Civilian Hospital Medical Staff Appointment
M = Military Service (Including Hospital Staff Appointments) **O** = Other

CODE	NAME AND ADDRESS OF ENTITY	DATE (From MO/YR to MO/YR)
		to
		to
		to
		to
		to
		to
		to
		to
		to

In the following section, please explain any gaps of two months or more in your education, post-graduate training or work history:

PROFESSIONAL LICENSES

PROFESSIONAL LICENSES	LICENSE NUMBER	DATE OBTAINED	EXPIRATION DATE
STATE LICENSE			
FEDERAL DEA REG NUMBER			
STATE CDS LICENSE NUMBER			
CLIA CERTIFICATE			

Have you been or are you <u>currently</u> licensed in any other state? If YES, please complete the following:

LICENSE NUMBER	STATE	DATE OBTAINED	EXPIRATION DATE

(Please attach a copy of licenses listed above.)

REFERENCES

List, as professional references, three or more peers who have worked extensively with you or who have been responsible for professional observation of your work during the past two years.

(References should not be relatives or current partners.)

NAME	STREET ADDRESS	CITY	STATE	ZIP	PHONE NUMBER

PROFESSIONAL LIABILITY INSURANCE COVERAGE

NAME OF CARRIER	POLICY NUMBER
ADDRESS AND PHONE NUMBER OF CARRIER	
AMOUNTS PER OCCURRENCE/AGGREGATE	DATES OF COVERAGE
Number of settlements/judgments in the past 10 years	Number of claims pending

Do you participate in the Louisiana Patients' Compensation Fund? ○ YES ○ NO

Has current liability insurance carrier excluded any procedures from insurance coverage? (If yes, attach explanation) ○ YES ○ NO

Self Insured? ○ YES ○ NO

(Please attach a copy of the Certificates of Insurance and any claims paid in the past 10 years.)

GENERAL QUESTIONS

Please check the appropriate response to the following questions:	**YES**	**NO**
1. Have any disciplinary actions ever been instituted against your license to practice medicine in any state or country, or are any such actions currently pending against you?		
2. Have any disciplinary actions ever been instituted against your DEA registration or CDS license, or have you voluntarily surrendered or limited your registration, or are any such actions pending?		
3. Have you ever been convicted of, or pleaded nolo contendere to, or are you currently under investigation for federal or state felony or other criminal charges or have you ever served a prison sentence?		
4. Have you ever been suspended from the Medicare or Medicaid program, or has your participation status ever been modified?		
5. Have your clinical privileges at any hospital or health care institutions been voluntarily or involuntarily revoked, not renewed, or subject to probationary or other disciplinary conditions, or have proceedings been instituted or recommended by a hospital administration, medical staff committee or governing board?		
6. Have you ever received sanctions from any regulatory agencies (e.g., CLIA, OSHA, etc.)?		
7. Are you currently engaged in the illegal use of drugs? "Illegal use of drugs" means the use of controlled substances obtained illegally, not obtained pursuant to a valid prescription or not taken in accordance with the direction of a licensed health care practitioner. "Currently" means within the past two years.		
8. Do you currently have any ongoing physical or mental impairment or condition which would make you unable, with or without reasonable accommodation, to perform the essential functions of a practitioner in your area of practice, or unable to perform those essential functions without a direct threat to the health and safety of others?		
9. Do you, your business entity or any family member have any financial relationship with any medical enterprise or business?		

If you answered YES to any of the questions above, please attach a full explanation on a separate page.

10. Are you presently a named defendant (or otherwise adversely involved) in an open and ongoing administrative/legal proceeding pursuant to a petition for damages before a medical review panel, malpractice suit, or are you the subject of any other accusation of negligent care?		
11. Have any settlements, judgments or payments been made by you or on your behalf in a medical malpractice action or potential action (during the past 10 years)?		
12. Has any medical review panel ever found that you have failed to meet the applicable standard of care as complained in the petition for review?		

If you answered YES to question 10, 11 or 12, complete a separate sheet or a narrative for each claim.

REQUIRED ATTACHMENTS

- ✓ Certification(s), Including Educational Certifications and Training (CMEs)
- ✓ State Licenses including current licenses held in other states, State CDS license and Federal DEA Registration
- ✓ Curriculum Vitae
- ✓ Certificate(s) of Insurance
- ✓ List of professional liability insurance carriers for the past 5 years.
  (If different than current carrier, include information as requested on page 7)
- ✓ History of Claims Paid (Last 10 years)
- ✓ Additional Practice Locations (Include all information required for other practice locations)
- ✓ Explanation of any "Yes" Answer(s) from General Questions Section on page 8.
- ✓ Current W-9 Form (Tax ID)
- ✓ ECFMG (If applicable)
- ✓ Health Plan Agreement (If applicable)

STATEMENT TO APPLICANTS

All providers applying for network participation have the right to review the credentialing application and supporting documents. Exceptions may vary as prohibited by law or Health Plan policy.

In the event that credentialing information obtained from other sources varies substantially from the information submitted on this application, you will be notified of the discrepancy either by telephone or in writing. You will have the opportunity to submit additional information to correct the discrepancy or provide clarification which may positively impact the credentialing decision.

PROVIDER STATEMENT TO RELEASE INFORMATION

All information and documentation submitted by me in this application is correct and complete to my best knowledge and belief.

I acknowledge that any material misstatements in or omissions from this application may constitute cause for denial of my application for network participation.

I consent to the release of all information that may be relevant to an evaluation of my credentials, including information about disciplinary actions or other confidential or privileged information, to Plan or its affiliates or successors. I understand and agree that this consent is irrevocable for any period during which I am Plan provider. I release Plan, its affiliates and successors and their representatives from any and all liability for their acts performed in good faith and without malice in obtaining information and evaluating my credentials. Plan is defined as the Health Plan that is requesting the credentialing information.

	X
NAME (Please Print)	**SIGNATURE**

ORIGINAL SIGNATURE DATE	**FIRST REAPPROVAL DATE**	**SECOND REAPPROVAL DATE**

Plan accreditation guidelines may require this application signature date to be no more than 180 days old at the time of credentialing.